

FILED MAR 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Simpson

4582

State File No.

BIRTH NO.		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>196</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>				c. LENGTH OF STAY (In this place) <u>2 Weeks</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Baptist Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>Route # 2 Fair Grove, Mo.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Mildred</u>		b. (Middle) <u>A</u>		c. (Last) <u>Murphy</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan 22 1910</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		9. AGE (In years last birthday) <u>39</u>		11. BIRTHPLACE (State or foreign country) <u>Marshall, Ill.</u>	
13a. FATHER'S NAME <u>van Kraemer</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Phillip S. Murphy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Phillip Murphy Rt # 2 Fair Grove, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis (toxic)</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Psychoses (Dementia Praecox) (or Toxic)</u> DUE TO (c) <u>Underwent Fever app. 1/20</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Influenza 2-1-49</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>13 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-3-49</u> , to <u>2-27</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2-27</u> , 19 <u>49</u> , and that death occurred at <u>10:30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Dr. Simpson</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>2-28-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/2/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3-1-49</u>		REGISTRAR'S SIGNATURE <u>W. H. Handley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Lohmeyer</u>		ADDRESS <u>Springfield, Mo.</u>	

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 19 1950

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Walter E. Hamilton

Signed _____

Student Embalmer

Licensed Embalmer No. *3808*

P. O. Address *Springfield Mo.*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.